MOTION FILED
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No. 83-558

IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

IRVING INDEPENDENT SCHOOL DISTRICT,

Petitioner,

vs.

HENRI and MARY TATRO, Individually and as Next Friend of AMBER TATRO, A Minor,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

MOTION FOR PERMISSION TO FILE BRIEF *AMICUS CURIAE* AND BRIEF FOR THE NEW YORK STATE COMMISSION ON THE QUALITY OF CARE FOR THE MENTALLY DISABLED, PROTECTION AND ADVOCACY SYSTEM, AS *AMICUS CURIAE*

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On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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Motion for Permission to File Brief Amicus Curiae

The New York State Commission

on the Quality of Care for the Mentally

Disabled, Protection and Advocacy System, respectfully moves this Court for permission to file the accompanying brief Amicus Curiae in support of respondents. Consent to file this brief has been sought from the parties; while respondents have consented, counsel for petitioner has not. Leave of this Court therefore is requested under Rule 36.

The interest of the amicus is set forth below. The accompanying brief addresses issues of fact and law concerning the simplicity of the procedure at issue, its treatment as a "related service" in other states, and the federal and state funding mechanisms for providing the procedure. These issues have not been discussed by petitioner, and amicus has reason to believe that its brief will supplement rather than reiterate the arguments made by respondents.

INTEREST OF THE AMICUS

The Commission on the Quality of Care for the Mentally Disabled (the "Commission") is an independent state agency within the Executive Department of the State of New York. It is designated by the Governor as the agency responsible for the establishment of a state-wide system of protection and advocacy for developmentally disabled persons, as mandated by the Developmentally Disabled Assistance and Bill of Rights Act. 42 U.S.C. § 6001 et seq. The Commission devotes significant resources to the problems that developmentally disabled children confront in securing the "free appropriate public education" required under the Education for All Handicapped Children Act, 20 U.S.C. § 1401 et seq. (the "EAHCA"). From its direct experience with the difficulties developmen-

tally disabled persons face in all aspects of their lives, the Commission has come to realize that education is often the key factor in shaping their potential ability to become productive and contributing members of society. Thus, the question of what is a "related service" under the EAHCA is of crucial significance to the Commission's protection and advocacy function, and to the children it serves.

SUMMARY OF ARGUMENT

Clean intermittent catheterization (CIC) is a simple procedure which places little in the way of financial burdens on local school districts but is essential to the ability of a child with spina bifida to attend school. CIC is so simple that many children regularly perform it. School districts around the country are providing CIC to handicapped children with no evidence of any financial burden. Substantial funds are available to local school districts from both states and the federal government to assist school districts in meeting their obligations under the EAHCA. Indeed, there is nothing which prevents state governments from assuming the costs not

covered by federal grants to fulfill the mandate of the EAHCA.

ARGUMENT

CIC Is A Simple, Inexpensive Procedure Regularly Provided To Handicapped Children, Without Which They Cannot Attend School, And For Which Local School Boards Receive Substantial Federal And State Funds

This case presents the limited situation of a procedure which must be performed periodically during the day at frequent enough intervals that a child could not attend school without the procedure being performed. This case does not involve health services that could be performed outside of the school day because they are not required at intervals of less than four to six hours. Thus the spectre,

advanced by petitioner and amicus National School Boards Association that under the decision below, school boards would be liable for expensive health services such as kidney dialysis is inaccurate and misleading. Kidney dialysis can be performed outside of school hours and is generally not required more than three times weekly. In addition, the EAHCA expressly excludes the most expensive form of health services, those performed by a physician (except for diagnosis and evaluation), from the scope of related services which must be provided a handicapped child. 20 U.S.C. § 1401(17).

A. CIC is a Simple, Inexpensive Method of Providing Management of the Neurogenic Bladder Condition Without Which Spina Bifida Children Could Not Attend Public School.

Catheterization is required by the vast majority of children with spina bifida. In the case of Amber Tatro, her physician prescribed catheterization by the generally accepted method, CIC, at intervals of three hours, one of which occurred during the school day. Tatro v. Texas, 703 F.2d 823, 828 n.5 (5th Cir. 1983) ("Tatro II"), "Management of the neurogenic bowel and bladder is one of the most critical needs if the child with spina bifida is to have good health, social acceptability, and self-esteem. Poor management can result in repeated urinary tract

infections, kidney damage, and even death. In addition, poor management results in constant wetness, skin problems, and odor, making the child socially unacceptable and self-deprecating." M. Woldranch, The Needs of Children with Spina Bifida 14-15 (1983). The bladder problems of children with spina bifida are the result of "the defect in the spinal cord [which] prevents the impulses from reaching the brain" which would otherwise control the bladder functions. C. Swinyard, The Child With Spina Bifida 20 (Spina Bifida Assoc. of America 1980). In addition, the functional relationship between the bladder wall muscle and the sphincter may be impaired. The sphincter is a muscle which acts as a valve that opens to allow urine to flow from the bladder

into the urethra and then closes and stops the flow. Id. As a result, a spina bifida child may suffer both regular leakage and an inability to fully empty the bladder. The most serious danger to a spina bifida child from the bladder is the "passage of urine from the bladder back into the ureters (called urinary reflux) with resultant enlargement of the ureters and destruction of the kidneys from urinary pressure and infection . . . The key to preventing this complication is frequent and complete evacuation of urine from the bladder . . . [A]ll children should try to empty the bladder on a timed schedule which is suitable for them." Id. at 21-22. The District Court found that there is a risk of serious injury if Amber Tatro

does not receive catheterization during school hours. Tatro v. Texas, 516 F. Supp. 968, 977 (N.D. Tex. 1981).

The simplicity with which CIC can be administered is clear from the procedures prescibed for Amber and other children by the Texas Scottish Rite Hospital for Crippled Children set out by the Court of Appeals. Tatro II, 703 F.2d at 828-29, n.5. CIC involves nothing more than the insertion of a rubber or plastic tube one inch into the urethra. The urine in the bladder then drains out and the tube is removed. The process is no more complex or dangerous than taking a child's temperature through the rectum, indeed less so because a thermometer is usually made of glass.

The procedure is so simple that a child can perform it and usually does so for herself. A study demonstrated that a child with the mental age of a five year old can be trained to self-catheterize using CIC. Hannigan, Teaching Intermittent Self-Catheterization to Young Children with Myelodysplasia, 21 Developmental Medicine and Child Neurology 365 (1979). The United States Department of Health Education and Welfare funded the preparation of a booklet entitled "Intermittent Self Catheterization for Girls Ages 4 to 7 Years," and another booklet for boys, both by Hannigan and Hart, designed to be read to children who may not even be able to read but may be able to catheterize themselves. The ability of most children to self-catheterize means that even the minimal costs of pro-

viding CIC to young children will come to an end as the child learns to provide for herself.

B. CIC Is Regularly Provided To Handicapped Children By School Boards Around The Country

One measure of whether providing CIC to handicapped children is financially burdensome on school districts is the extent to which the districts are currently providing CIC services to children. The state regulations for programs under the EAHCA generally do not spell out in detail all the individual health services included as "related services." Accordingly, amicus undertook a mail and telephone survey of twenty states chosen to assure a cross section geographically

and by population density. Fourteen states responded; these states and the names and titles of officials providing the information are set forth in the footnote below.[1]

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[1] State Boards of Education surveyed:
Arizona - Shirley Bowman, Education Program Specialist for the Federal Projects
California - Bob Evans, Consultant Special Education and Asst. to the Dir. of Special Education
Florida - Dr. Wendy Cullar, Dir. of Exceptional Students
Kentucky - Lynette Uhl, Dir. of Unit of Procedural Safeguards
Illinois - Betty Endicott, Special Education Specialist
Minnesota - Marilyn Sorenson, Education Specialist
Mississippi - Carolyn McGuire, Asst. Program Supervisor, Special Ed. Section
Montana - Gail Gray, Director of Special Education
New Hampshire - Robert Kennedy, Dir. of Special Ed. Section
New Jersey - Mari Malenaar, Planning Associate, Division of Special Education
North Carolina - Beverly Gardner, Secretary of Related Services
North Dakota - Shelby Niebrgall, Asst. Dir. of Special Ed.
Oklahoma - Glenn J. Haring, Asst. Officer for Procedural Safeguards,
(Contined on p. 11)

Not a single state that responded reported knowing of a school district that refused to provide CIC services needed by a handicapped child.[2] Eleven of the fourteen respondents reported that school districts in their states were providing CIC services.[3] Once a doctor prescribes catheterization, the daily school regime is usually worked

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Special Ed. Section
Wisconsin - Dr. Betty Ross-Thomson, Supervisor of Physical and Other Health Impaired

2 A school district in Pennsylvania refused to provide CIC services, leading to the litigation in Tokarcik v. Forest Hills School District, 665 F.2d 443 (3d Cir. 1981), cert. denied sub nom. Scanlon v. Tokarcik, 458 U.S. 1121 (1982), in which the court held that CIC was a related service.

3 California, Florida, New Hampshire, Kentucky, Illinois, Minnesota, Mississippi, New Jersey, North Carolina, Oklahoma, Wisconsin. In addition the record herein reveals that the Dallas school district adjacent to petitioner provides CIC services. Pl. Ex. 5 B (I.H. Tr. 19).

out between the parents and the school district. The procedure is performed by a school nurse or other school personnel trained for the purpose. Providing CIC service usually does not entail additional personnel costs for a school district.

Amicus also requested information of states concerning dispensation of medication by school personnel to children because of the parallels to providing CIC services. Dispensation of medicine, like CIC, requires a prescription by a physician, involves a dosage that must be taken at frequent intervals including school hours, and can be performed by someone other than a physician with relatively little training. Twelve of the fourteen reporting states (all but Arizona and

Wisconsin) reported that school districts in their states were dispensing medication prescribed by physicians, either by a nurse, school aide or teacher. Again no state reported a single school district refusing to administer prescibed medication. The petitioner school district herein administers medication. Pl. Ex. 2 (Tr. 38).

There is little in the way of reported decisions as to whether CIC is a "related service," which may indicate that most school districts are providing the service on request. In addition to the court below, one other

decision also held that CIC must be provided to handicapped children,[4] and there are none to the contrary.

In Tokarcik v. Forest Hills School District, 665 F.2d 443 (3d Cir. 1981), cert. denied sub nom. Scanlon v. Tokarcik, 458 U.S. 1121(1982), the Third Circuit held that CIC fell within the meaning of a "related service" under the EAHCA. Id. at 455-459. The Court considered the alternatives to CIC (placement in a special class for handicapped children or at-home tutoring), but decided that CIC was the most economical and the best method of providing an integrated, meaningful educational program

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[4] See also Hairston v. Drosick, 423 F.Supp. 180 (S.D. W.Va. 1976), reaching the same result under the Rehabilitation Act of 1973, 29 U.S.C. §794.

for the handicapped child in the least restrictive environment. Id. at 458 n.26.

The Court of Appeals noted that when considering CIC, the "difficult value choices between placing the burden of fiscal limitations on handicapped children as opposed to school districts, or between advantaging a handicapped child by mainstreaming rather than enhancing the education of her nonhandicapped students by excluding her, do not even confront us." Id. at 458. The Court explained:

> The CIC service has no serious potential for disrupting the education of Amber's nonhandicapped peers. In fact the district court found that, "Amber Tokarcik places absolutely no burden on her teacher." App. 50.

> Nor does it pose an undue drain on the school system's financial situation. There are simply no legitimate educational or fiscal grounds for denying Amber a right to participate in the regular classroom setting. Id.

A closely analogous case found a service very similar to CIC to be a "related service." In Department of Education, State of Hawaii v. Katherine D., 531 F.Supp. 517 (D. Hawaii 1982), a four year old girl suffering from cystic fibrosis was required to use a tracheotomy tube to assist her breathing. In order for Katherine to attend public school, a trained person had to be available to attend to her various health needs including suctioning excess mucus from her lungs, administering medication before lunch, and reinserting her tracheotomy tube should

it become dislodged. Id. at 521. The Court held that a home-bound program did not satisfy the meaning of "least restrictive environment" as prescribed by the federal regulations. Id. at 525. Evidence showed that the services Katherine required could be performed by a school nurse or other trained person who need not be a physician. Id. at 526. Thus, the services Katherine required were "school health services" covered by the "related services" provision of the EAHCA. Id.

In addition to state practice and case law, administrative interpretation of the "related services" requirement supports a finding that CIC is such a service. See Tokarcik v. Forest Hills School District, supra, 665 F.2d at 456-57. In early 1981, the Department

of Education issued a notice of interpretation stating that CIC is a related service. 46 Fed. Reg. 4912 (Jan. 19, 1981). Subsequently, the new administration suspended the interpretation, see 46 Fed. Reg. 12495 (Feb. 17, 1981), but its latest action on the issue is a de facto recognition of CIC as a related service. On May 8, 1981, the agency again "postponed" the earlier interpretation pending a comprehensive review, 46 Fed. Reg. 25614, but allowed CIC as a reimbursable cost under EAHCA, stating:

> The Secretary is concerned that handicapped school children be educated to the greatest extent possible in the least restrictive environment. The Secretary is also concerned that the differentiation between related services and medical services be clarified. The Secretary declines to issue an interpretation based on

> regulations that are ambiguous and subject to review. In the interim, the provision of clean intermittent catheterization as a related service will be treated as an allowable cost under Part B of the EHA. Id. (emphasis added).[5]

By allowing the states to claim catheterization as a "related service" for EAHCA funds, the Department of Education continues to recognize catheterization as a "related service." In the almost three years that have passed since May 1981, the authorization of CIC as a related service has not been altered.

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[5] Petitioner fails to include in its quotation of this announcement the crucial last sentence (Brief of Petitioner at 23), thus omitting the fact that CIC as a "related service" is an allowable cost under of the EAHCA.

The few cases on point and the only federal interpretation that addresses CIC indicate that the concept of "mainstreaming" or providing education in the least restrictive environment, which is a fundamental goal of EAHCA (see 20 U.S.C. §1412(5)), is also the most cost effective method for providing education to handicapped children. As the Court noted in Tokarcik,

> [I]f the school district did not have a nurse of aide available to catheterize Amber, it would still be obligated to provide her with an appropriate education. And the two possible alternatives -- at home instruction or a special class for the handicapped -- would appear to be less cost beneficial. 665 F.2d at 458 n.26.

The willingness of petitioner school district to support education for Amber Tatro in her home or in a private school negates any claim to financial concerns about providing CIC in the public school. If anything, the record seems to indicate that the refusal to provide Amber Tatro with CIC stemmed from the fact that the school district's supervising school nurse was unfamiliar with the CIC procedure. Pl. Ex. 5 B (I.H. Tr. 140-147). Whatever the reason, it is contrary to the requirements of the EAHCA.

C. Substantial State and Federal Funds Are Available To Assist School Boards in Meeting Their Obligations To Handicapped Children Under EAHCA.

The cost of providing CIC services is nominal; but even if it were more expensive, school boards would be obligated to provide them. School boards need not assume the financial burdens imposed by the EAHCA; the question of whether the state or the local school board should pay the costs is purely one of state law. While the EAHCA imposes a matching fund requirement on states, local school boards face no similar obligation. 20 U.S.C. §1411(c)(2)(B). Moreover, no state is required to accept funding under EAHCA. If a state believes the requirements of EAHCA are too costly it

may decline the federal funds and be free of all federal requirements under EAHCA.

Congress was not unaware that a commitment to educate every handicapped child is a costly one. S. Rep. No. 168, 94th Cong., 1st Sess. 14, 15 (1975); H. Rep. 332, 94th Cong., 1st Sess. 12 (1975).Years before the passage of the EAHCA, however, Congress recognized that many more than half of all handicapped children throughout the nation were largely without meaningful educational programs. Between 1966 and 1974, several federal grant programs were enacted in the hope of encouraging states to expand and improve such programs. S. Rep. 168, 94th Cong., 1st Sess. 5 (1975). These block grants proved inadequate: the

limited funds available required states to make arbitrary decisions as to which children would benefit, thus leaving most of the handicapped without additional assistance. Id. at 15.

The passage of the EAHCA in 1975 represented a greatly increased commitment of funds by the federal government, with a concomitant imposition of legal duties upon the states and localities that choose to participate. The receipt of federal funds was made contingent on the provision to every handicapped child of a "free appropriate public education" and "related services" in the regular classroom to the maximum extent appropriate. 20 U.S.C. §1412.

Congress envisioned a federal-state-local partnership to finance this expansion of opportunity for handicapped children. No one governmental entity solely was to bear the financial responsibility. While state and local budgetary concerns were voiced repeatedly, Congress "reject[ed] the argument that the Federal Government should only mandate the services to the handicapped children if, in fact, [federal] funds are appropriated in sufficient amounts to cover the cost of this education." S. Rep. No. 168, 94th Cong., 1st Sess. 22 (1975).

As Senator Stafford stated, "Make no mistake, educating our children is still very much a state responsibility, and this bill does not change that. It intends that the states and local

districts provide the same support for handicapped children as they do for all other children. The Federal dollars are to supplement the state and local commitment." 121 Cong. Rec. 20428 (Nov. 19, 1975). Just as there is "a significant increase in the Federal contribution to the education of handicapped children, the States will also be required to provide a commensurate increase in their commitment to the education of handicapped children." 121 Cong. Rec. H11353 (Nov. 18, 1975) (statement of Rep. Mink).

Accordingly, the EAHCA provides a basic formula for allocating federal monies to states and local districts. To calculate the federal grant, the number of handicapped children receiving "special education and related

services" (up to a cap of twelve percent of that state's entire student population)[6] is multiplied by forty percent of the national average per pupil expenditure. 20 U.S.C. § 1411(a). In other words, the federal government contributes for every handicapped child, forty percent of average per pupil education costs.

Local districts receive a direct pass through of 75% of the federal grant to a state; 25% of the state allocation must be used for direct and

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[6] The twelve percent cap was based on Congress' estimate of the maximum number of handicapped children in the country. The purpose of the cap was to prevent against overcounting or mislabelling of children as handicapped. In 1981, for example, 10.47 percent of school aged children, 3-21, were classified as handicapped for purposes of the Act. U.S. Department of Education, Fifth Annual Report to Congress on the Implementation of Public Law 94-142 at 4 (1983).

supportive services for handicapped children, with a small allowance for administrative costs. 20 U.S.C. § 1411(c)(1). Moreover, the state allocation must be matched by the state with other than federal funds; no matching obligation whatsoever is imposed upon school boards. 20 U.S.C. § 1411(c)(2)(B).

Finally, the EAHCA requires that the federal funds must be used to supplement and increase special education programs, and "in no case to supplant" state and local funds used for special education, 20 U.S.C. § 1413 (a)(9), and that the funds be passed through to localities in proportion to the number of handicapped children in the district. 20 U.S.C. § 1411(d).

Under this scheme, the amount of federal monies injected into the nation's school districts is not insubstantial. The figure has grown dramatically from 200 million dollars in fiscal year 1977 to 931 million dollars in fiscal year 1983. U.S. Department of Education, Fifth Annual Report to Congress on the Implementation of Public Law 94-142 at 16 (1983). Texas receives the second largest allotment of federal funds: over 61 million dollars in 1983. Id. at 169.

As Congress envisioned, however, these federal funds are supplemental to monies contributed by the State of Texas and its local governments: the contemplated three part partnership is fully realized. The state government provides to localities a large propor-

tion of general education costs, and for special education, vastly more than the required match of the 25% of the federal allocation. Local districts significantly benefit from the 75% federal pass through, as well as from the state contribution.

State aid in Texas is distributed through the Foundation School Program, which supplements local property taxes in order to guarantee, regardless of tax base, "that each school district ... has adequate resources to provide ... a basic instructional program suitable to [each student's] education needs." Tex. Educ. Code Ann. § 16.001 (Vernon Supp. 1982-83).

The amount of money given to local school districts by the State of Texas is massive. In 1982-83, a total of 8.456 billion dollars was spent in the state for elementary and secondary education.[7] Of this total, 3.6 billion dollars came from state revenues. Approximately 380 million dollars of the state funds were earmarked specifically for special education.[8] In addition, localities received the 75% allocation of some 61 million dollars in federal aid.

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7 Telephone interview with Thomas C. Patton, Director, Division of State Funding, Texas Education Agency, March 20, 1984.

8 Letter from Raymon L. Bynum, Commissioner of Education to Texas Governor Mark W. White (July 26, 1983) (enclosing Foundation School Fund budget, 1982-83).

A detailed statutory formula governs the distribution of state monies for special education and related services. Tex. Educ. Code Ann. § 16.104 (Vernon Supp. 1982-83). Each school district is entitled to thirty "special education personnel units" for its first 3,000 students, one unit for each additional 100 students up to 6,000, and .85 units per 100 students thereafter. A personnel unit is equal to one special education teacher or approximately two educational aides, for example. Tex. Educ. Code Ann. § 16.056. A district receives 100% of its allocation if it has a 12% handicapped student body (the equivalent of the federal cap); the allocations decrease as the percentage of handicapped students in a district declines. Tex. Educ. Code Ann. § 16.104. Thus,

the Texas formula takes into account the needs of the smaller school districts as well as the larger, and variances among districts in the percentages of handicapped children.

Assuming a school district of 3,000 students, 12% or 360 of whom are handicapped, 30 additional teachers or one teacher for every twelve handicapped children may be provided, for example. The locality may divide its units as it requires, hiring teachers, aids or specialists within its allocated units. The salaries of such staff are paid out of state revenues from the Foundation School Program Fund, not from local taxes. Tex. Educ. Code Ann. § 16.104(o). The State contributes an additional $400 per unit which may be used for a variety of

support services, such as instructional materials, and related services. Tex. Educ. Code Ann. § 16.104(d)(6).

Thus, the State of Texas has demonstrated its willingness and capacity to provide funds to support public education in the state and special education as well. Texas' anticipated special education expenditure of 411 million dollars for 1983-84 is 27 times its 25% matching requirement of funds it received under the EAHCA. The State, with its broad tax base, can and does provide funds for the education of handicapped children. Texas has acted in accordance with the intent of Congress in financing special education programs so that children like Amber Tatro can attend the regular public schools and progress educationally, socially and emotionally along with other children her age.

CONCLUSION

For the foregoing reasons, the judgment of the United States Court of Appeals for the Fifth Circuit should be affirmed.

Respectfully submitted,

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